TQIC REFERRAL FORM

Temporary Quarantine and Isolation Center (TQIC)
524 Ka'aahi Street Honolulu, HI 96817

TQIC Provider Phone Line: (808) 683-5484 | TQIC Fax: (855) 719-1083

Instructions For the ED/hospital: *admissions/referrals are made via calling the provider warm line (Ph: 808-683-5484) between 8:00am and 5:00pm and fax the TQIC referral form with pertinent medical records attached (F: 808-425-4013)*

Community referrals *should call the CARES line 808-832-3100 and fax this referral form to (F: 808-425-4013). All referrals must be accepted BEFORE the patient is physically sent.*

**Note: Competition of this form does NOT guarantee admission to TQIC.*

CARES Line Contact Date:		Individual Being Referred:	
CARES Line Staff Name:		DOB:	
Referral Organization:		Gender: ☐ Male ☐ Female ☐ Transgender	
Name of Person Making Referral:		Height: ft. in.	Weight: lbs.
Contact Person:		Veteran Status:	Legal Status:
Phone:	Fax:	Length of Time in Hawaii:	
Address:		Address/or location frequents:	
		Emergency Contact Name and Phone:	
		Client Phone/Cell Number:	

COVID-19: PLEASE ATTACH CHEST X-RAY IF CURRENT AND AVAILABLE

Current signs/symptoms of COVID-19? ☐ YES ☐ NO	If yes, date when symptoms started:
Symptoms: ☐ Shortness of Breath ☐ Chest Pain ☐ Loss of Taste ☐ Loss of Smell ☐ Fatigue ☐ New Cough ☐ Headache ☐ GI: diarrhea, nausea, vomiting	
Other symptoms:	
Contact with confirmed COVID-19? ☐ YES ☐ NO	
Last Test Date for COVID:	Result: ☐ Pending ☐ Negative ☐ POSITIVE
If POSITIVE, has DOCD been notified/patient assigned to a contact investigator? ☐ YES ☐ NO	
Investigator Name:	Contact:
Testing Facility/Provider Name:	Contact:
Travel within the past 14 days? ☐ YES ☐ NO	If yes, where?
Works in health care setting or high-risk job setting (i.e. fire department, EMS, etc)? ☐ YES ☐ NO	
Last set of vital signs if available *(or attached within clinical notes)*: Temp: Sp02: RR: BP: HR: Height: Weight:	

HEALTH PLAN INFORMATION:

Health Plan:	Member #:
Service Coordinator:	Contact #:

MENTAL HEALTH:

1. Current Mental Status: ☐ Alert ☐ Oriented to time/place ☐ Memory loss: ☐ Short-term ☐ Long-term ☐ Both	
2. Mental Health History:	
3. Mental Health Provider/Psychiatrist:	Contact #:
Other Mental Health CM or PO:	Contact #:

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4. Community Care Services (CCS) member? ☐ YES ☐ NO If Yes, Case Manager (CM) Name and Contact #:	
5. History of violent behavior? ☐ YES ☐ NO	6. History of self-harm/past suicidal attempt(s)? ☐ YES ☐ NO
CHEMICAL DEPENDENCY STATUS:	
1. History of substance use/ chemical dependency? ☐ YES ☐ NO If yes, list substance(s):	
2. Drug Screen Results? ☐ POS for _____ ☐ NO Drug of choice:	
3. Route of drug administration:	
4. History of seizures in withdrawal?	
5. History of overdose? ☐ YES ☐ NO	6. History of smoking? ☐ YES ☐ NO Quit date:
7. Frequency of use:	
HOMELESSNESS HISTORY:	
1. Length of current homeless episode:	
2. Name of homeless outreach provider:	
3. Contact Number:	
4. Area most frequent homeless:	
ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING (ADLS) WITHOUT ASSISTANCE:	
✓ Walk at least 30 feet? ☐ YES ☐ NO	✓ Feeds self? ☐ YES ☐ NO
✓ Ambulatory aides (wheelchair/walker)? ☐ YES ☐ NO If yes, able to transfer independently? ☐ YES ☐ NO	✓ Toilet self? ☐ YES ☐ NO ✓ Bathe self? ☐ YES ☐ NO
✓ Able to prep simple meals independently? ☐ YES ☐ NO	✓ Maintain good hygiene? ☐ YES ☐ NO
✓ Ability to communicate w/ English? ☐ YES ☐ NO If no, what language?	
MEDICAL CONDITION:	
1. Positive PPD? ☐ YES ☐ NO	Date done: / Date Read:
Chest X-ray date:	Results: ☐ Positive ☐ Negative
2. Can self-administer & monitor own meds? ☐ YES ☐ NO	(please attach medication list)
3. Adherent with medication prescriptions? ☐ YES ☐ NO	
4. Requires dialysis? ☐ YES ☐ NO	If yes, location and days:
5. History of immunocompromising disease? ☐ YES ☐ NO	If yes, list:
6. Special diet requirements?	
7. Other Comments: ***Note:*** *There are limited ADA units available. No Smoking on property. TQIC provides care 24/7 through nursing and case management with providers on duty. TQIC cannot assist with airway management.*	
PRIOR FOLLOW-UP APPOINTMENTS SCHEDULED:	
1. Date:	Time:
Physician Name:	Physician Contact:
2. Date:	Time:
Physician Name:	Physician Contact: